



Yale Journal of Health Policy, Law, and Ethics

Volume 1

Issue 1 *Yale Journal of Health Policy, Law, and Ethics*

Article 15


2001

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Jean Reith Schroedel

Pamela Fiber

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Recommended Citation

Jean R. Schroedel & Pamela Fiber, *Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women*, 1 YALE J. HEALTH POL'Y L. & ETHICS (2001).

Available at: <https://digitalcommons.law.yale.edu/yjhple/vol1/iss1/15>

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Punitive Versus Public Health Oriented Responses to Drug Use by Pregnant Women

Jean Reith Schroedel, Ph.D.* and Pamela Fiber, M.A.†

During the past fifteen years, the term fetal abuse has been applied to physical and developmental harms caused by prenatal drug exposure, but not to other preventable threats to fetal well-being.¹ Although *Roe v. Wade* established the legal rationale for fetal abuse prosecutions,² which held that a state may have a compelling interest in intervening in a woman's pregnancy after the fetus reaches viability, states did not initially use *Roe* to prosecute pregnant women whose substance abuse threatened fetal well-being.³ The situation began to change in the mid-1980s, when media attention on the problems of "crack babies"⁴ combined with technological advances in *in utero* fetal health monitoring to create a public outcry against pregnant substance abusers.⁵

Governmental responses to prenatal drug exposure have proceeded under two venues: the criminal justice system and state legislatures. The purpose of the criminal justice system is to determine whether a crime has been committed and, if so, to punish the guilty parties—not to determine the most effective policy to combat a particular social ill. Not surprisingly, therefore, most policies emanating from the criminal justice system are punitive in nature.⁶ Also, most decision-making within the criminal justice system occurs on an ad hoc basis, without substantial input from experts. Police, prosecutors, and judges are rarely forced to confront facts that contradict their framework of analysis.⁷

In contrast, the legislative process is, by nature, a slow one that emphasizes deliberation and provides many opportunities for expert witnesses to provide input. As a result, there are substantial differences

* Jean Reith Schroedel is a Professor in the Department of Politics and Policy and Applied Women's Studies at Claremont Graduate University. Her most recent book is entitled, *Is the Fetus a Person? A Comparison of Policies Across the Fifty States*.

† Pamela Fiber is a Ph.D. candidate in the Department of Politics and Policy at Claremont Graduate University. She has written several articles on fetal policy making and is currently an adjunct faculty member at California State University at Fullerton.

‡ The authors wish to thank the Lyn and Norman Lear Foundation for its support.

between legislative and judicial responses to the problem of substance abuse by pregnant women.⁸ Politicians may try to impress their constituents by introducing legislation to “deal with” a “hot” topic, but these measures often experience formidable obstacles that prevent their enactment. With the exception of Nebraska, all states have bicameral legislatures, which means that there are many opportunities for experts to interject themselves into the legislative process. While this does not guarantee that all laws are well considered, a range of viewpoints are typically evaluated prior to the adoption of a particular policy. With respect to substance abuse by pregnant women, legislatures are far more likely than the criminal justice system to promulgate a variety of policies, both punitive and public health-oriented ones.

I. CRIMINAL JUSTICE SYSTEM RESPONSES TO PRENATAL DRUG EXPOSURE

Law enforcement officials, judges, and prosecutors have been at the forefront of efforts to criminalize fetal abuse, charging pregnant women with a range of offenses, including child abuse, child neglect, child endangerment, and delivery of drugs to a minor.⁹ These charges require the fetus to be defined legally as a “person.” Since 1985, criminal prosecutions of pregnant women have ensued in at least thirty-four states;¹⁰ with most women being charged with child abuse or a similar offense. Although prosecutors have had some success obtaining convictions under existing child abuse and child neglect statutes, application of such laws to prenatal substance abuse entails legal gymnastics that have made reversals fairly common upon appeal. In the early 1990s, high courts in Florida, Kentucky, Ohio, and Nevada ruled that the fetus was not a “person” or a “child,” resulting in reversal of convictions for a lack of legislative intent.¹¹

To avoid these complications, prosecutors began exploring other strategies to hold substance abusing pregnant women criminally liable. One favored tactic takes advantage of laws prohibiting the delivery of drugs to minors to contend that the infant remains attached to the mother via the umbilical cord for several minutes after birth and could still be receiving narcotics through the umbilical cord. A positive toxicology screen is used to prove the charge. For these charges to be sustained, the usual standard of criminal culpability must be liberalized. However, conviction for criminal conduct requires *mens rea*, or criminal intent, which is very difficult to establish in these cases. Typically, this entails either “objective” evidence of recklessness and/or negligence or “subjective” intent with purposeful and knowing action.¹² Any serious attempt to assign criminal intent to these cases is likely to fail because of the social and economic conditions over which a pregnant woman has no control.

Other prosecution attempts remained true to the prenatal nature of the harm. In 1995, the Wisconsin Court of Appeals upheld an order placing a fetus in protective custody of the state to protect it from possible prenatal exposure to narcotics. This necessitated placement of the mother in a drug treatment center. The Wisconsin Supreme Court subsequently overturned this ruling, reasoning that the legislative branch has the responsibility of creating new law, not the judiciary.¹³

In *Whitner v. State*, the Supreme Court of South Carolina ruled that a viable fetus is a “child” or a “person,” and is thereby entitled to legal protection.¹⁴ The court reinstated an eight-year sentence against Cornelia Whitner, whose son tested positive for cocaine immediately after his birth. The U.S. Supreme Court denied review of the case in 1998.¹⁵ However, a related case from South Carolina was granted certiorari just two years later.¹⁶

During the 2000 term, the Supreme Court heard oral arguments in its first fetal abuse case, *Ferguson v. City of Charleston*.¹⁷ The pending issue was whether state hospitals can turn over urine test results of pregnant women to law enforcement officials for the purpose of prosecuting the women. In 1989, the Medical University of South Carolina (MUSC), in conjunction with local law enforcement, implemented a policy that mandated the testing of pregnant women suspected of cocaine use. Under the policy, maternity patients were to be tested when any of the following signs of cocaine use were present: (1) separation of the placenta from the uterine wall; (2) intrauterine fetal death; (3) no prenatal care; (4) late prenatal care (beginning after 24 weeks); (5) incomplete prenatal care (fewer than five visits); (6) pre-term labor without an obvious cause; (7) history of cocaine use; (8) unexplained birth defects; or (9) intrauterine growth retardation without an obvious cause.¹⁸ Physicians and hospital staff were given official sanction to conduct urine tests without warrants and without notifying patients that the findings could result in arrest and prosecution.

During the five years of collaboration between MUSC and the prosecutor's office, nearly 280 women, almost all African-American, were threatened with prosecution or arrested.¹⁹ In 1990, the American Civil Liberties Union (ACLU) reported that more than half of all arrests for prenatal exposure to harmful narcotics occurred in South Carolina. All of the women arrested in South Carolina were poor and a majority were African-American. According to the ACLU, South Carolina hospitals often decided to screen for narcotics use if a woman had not received early prenatal care—yet the state Medicaid program did not pay for prenatal care prior to nineteen weeks of pregnancy, causing a delay in poor women receiving prenatal care.²⁰

Racial issues aside, *Ferguson* hinged on the Fourth Amendment's protection from warrantless searches. Under the Fourth Amendment, a search is considered reasonable when legitimate government interests outweigh the intrusion on the rights of the individual. South Carolina argued that the search policy implemented by MUSC served "special governmental needs, beyond the normal need for law enforcement," and that those special governmental needs made it impracticable for governmental officials to obtain a warrant or even comply with the probable cause requirement.²¹ However, the Court has never applied this doctrine when the intention was to arrest and prosecute.²²

Critics charge the test and arrest approach followed in Charleston is both bad law and ineffective public policy. Forcing doctors at public hospitals to participate in the policy violates the confidential nature of the physician-patient relationship²³ and threatens the reproductive freedom of women.²⁴ The policy discriminates against poor and minority women because they are more likely to visit a state hospital than a private hospital.²⁵ Moreover, critics argue not only that pregnant users will avoid seeking prenatal care out of fear of prosecution,²⁶ but also that incarceration actually works against the goal of improving fetal health.²⁷

II. LEGISLATIVE RESPONSES TO PRENATAL DRUG EXPOSURE

More than two-thirds of all state legislatures have passed laws specifically designed to combat the problem of prenatal drug exposure.²⁸ The legislative responses to prenatal substance abuse can be divided into two basic categories: punitive and public health oriented approaches. Punitive approaches maintain that pregnant addicts must be coerced into behaving responsibly, while public health approaches emphasize education, medical treatment, and the provision of social services to pregnant addicts.

Regardless of their approach, states have been unwilling to commit new revenues to combating the problem. For example, two recent California governors—Deukmejian and Wilson—acknowledged that they vetoed bills passed by the state legislature because of the high cost associated with social services to drug-affected infants and their families.²⁹ And in Oregon, the relevant statute expressly notes the financial woes that accompany provision of services to pregnant substance abusers: "Because the growing numbers of pregnant substance users and drug- and alcohol-affected infants place a heavy financial burden on Oregon's taxpayers and those who pay for health care, it is the policy of this state to take effective action that will minimize these costs."³⁰ A few paragraphs later, the same statute states that "the Department of Human Services shall study, within

the resources of the department, the problem of substance-using pregnant and postpartum women and their infants.³¹

Despite the efforts of some politicians to move past the revenue problem and enact harshly punitive measures, most of the new laws have been surprisingly mild. During the late 1980s and early 1990s, many state legislatures introduced bills that singled out pregnant addicts for additional criminal penalties, but none actually passed.³² By 1994, the number of such proposals had so dramatically dropped that only two state legislatures (Indiana and Mississippi) considered bills, and neither were enacted.³³

A. Punitive Legislative Enactments

Punitive responses of state legislatures can be divided into two broad categories: civil commitment statutes and those involving social service agencies, primarily child welfare departments. The first approach is arguably the harshest because it mandates that substance-abusing women be involuntarily committed for the length of their pregnancy and allows the state to take custody of the child after birth. Under the social service agency approach, the worst punishment is that the woman may lose custody of the child after birth. At least a dozen state legislatures considered passing new civil commitment laws after state courts refused to stretch involuntary commitment laws to cover pregnant substance abusing women.³⁴ Three states—Minnesota, Wisconsin, and South Dakota—passed laws that allow for the involuntary commitment of substance abusing women, but they do not assure that the women are placed in appropriate facilities.³⁵ The Minnesota measure, for example, only applies to pregnant women who abuse “hard” drugs, such as cocaine and heroin.³⁶ Marijuana was specifically excluded, and recent attempts to add alcohol to list of proscribed substances failed. The civil commitment laws in Wisconsin and South Dakota are far more draconian; both cover alcohol, a legal substance, as well as a wide range of narcotics.³⁷ Furthermore, Wisconsin’s civil commitment law justifies state action based on the “adult expectant mother’s *habitual lack of self-control* in the use of alcohol beverages, controlled substances or controlled substance analogs, exhibited to a severe degree, unless the adult expectant mother is taken into custody.”³⁸

Civil commitment laws are actively being considered by state legislatures in Alaska, South Carolina, Texas, and Iowa. For example, this term, Iowa’s Senate, but not its Assembly, passed S.B. 2216, providing for civil commitment of certain chronic substance abusers. Although no two states have enacted identical measures, eighteen require the involvement of social service agencies (usually child welfare departments) when there is

evidence of prenatal drug exposure.³⁹ A number of states, like Minnesota, make it child neglect for a woman to give birth to a child addicted to alcohol or drugs.⁴⁰

The general laws of fourteen states require that medical providers and other professionals report to the appropriate state agencies positive toxicology tests in pregnant women and newborns, as well as any other evidence of possible drug use by pregnant women. Seven states have laws that mandate the reporting of prenatal drug exposure to the child welfare department (or an equivalent social service agency).⁴¹ The other seven states require that suspected cases of prenatal substance abuse be treated identically to cases of suspected child abuse or neglect, following the normal reporting requirements.⁴²

Because social service agencies in some of the remaining states have promulgated regulatory policies that require mandatory reporting of prenatal drug use, the practice extends beyond the eight states. For example, in 1988 the Department of Health and Rehabilitative Services in Florida promulgated a policy requiring anyone who has cause to suspect that a newborn is drug dependent to report it to the Florida Abuse Registry.⁴³ Child Protective Services investigators are then sent to determine the existence of abuse or neglect. However, a single positive toxicology screen is not *prima facie* evidence of abuse or neglect.⁴⁴

The harshest use of the child welfare system occurs in states that treat a positive toxicology screen or other evidence of prenatal drug exposure as *prima facie* evidence of child abuse, neglect, or its equivalent. For example, Minnesota defines “neglect” as including:

[P]renatal exposure to a controlled substance, as defined in Section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, or medical effects or developmental delays during the child’s first year of life that medically indicate prenatal exposure to a controlled substance.⁴⁵

Five additional states also find that prenatal drug exposure constitutes *prima facie* evidence of abuse, neglect, or its equivalent. Missouri classifies exposed children as “being at risk of abuse or neglect,”⁴⁶ Nevada defines them as “in need of protection,”⁴⁷ and Oklahoma states that they are “in need of special care and treatment.”⁴⁸ Indiana describes children with fetal alcohol syndrome and those born with even a trace amount of a controlled substance as “in need of services,”⁴⁹ while Iowa considers the presence of an illegal drug in a newborn’s system to be evidence of “child abuse.”⁵⁰ Other states are considering similar legislation.⁵¹

Other states do not specify that prenatal exposure to narcotics is *prima facie* evidence of child abuse or neglect. For example, Oregon provides only that “it is the policy of this state that the provider encourage and facilitate counseling, drug therapy and other assistance to the patient in order to avoid having the child when born, become subject to protective services.”⁵² On the other hand, Wisconsin specifically includes prenatal drug exposure within its definition of abuse, and also requires that: “Because of that compelling interest [in the potential life of the fetus], the court may order protective custody of that child even though such custody requires custody of the mother as well and the court may not have jurisdiction over the mother.”⁵³ Laws like those in Oregon and Wisconsin have generated far less attention than similar criminal cases involving prenatal drug exposure because most of these laws handle child welfare issues through the civil rather than criminal process. However, hundreds of women have lost custody of their babies on the basis of a single positive drug screen at birth.⁵⁴

In 1999, Virginia passed a law that allows an emergency removal order by the court if there is reason to suspect that a child is abused or neglected.⁵⁵ Such reasoning may include:

...a finding made by an attending physician within seven days of a child's birth that the results of a blood or urine test conducted within forty-eight hours of the birth of the child indicate the presence of a controlled substance not prescribed for the mother by a physician, or...a diagnosis by an attending physician made within seven days of a child's birth that the child has fetal alcohol syndrome attributable to *in utero* exposure to alcohol.⁵⁶

California law states that “a positive toxicology screen at the time of the delivery of an infant is not in and of itself a sufficient basis for reporting child abuse or neglect,” but it does trigger an assessment of whether the child is at risk.⁵⁷ The language in six other states with reporting requirements (Illinois, Kansas, Kentucky, Massachusetts, Utah, and Virginia) is ambiguous about the evidentiary significance of prenatal drug exposure for child abuse or neglect charges. However, such exposure has been interpreted as *prima facie* evidence of abuse in Illinois.⁵⁸

Most states with reporting requirements do not specifically state whether evidence of drug use during pregnancy can be used in a criminal case against the woman. Four states—California, Kansas, Kentucky, and Virginia—expressly prohibit the use of this information in a criminal prosecution of the woman.

B. Public Health Oriented Legislation

Most recent legislative enactments have embodied the public health approach, which views drug addiction as a disease that is best treated as a medical and psychiatric condition.⁵⁹ Thirty-three states have adopted laws that utilize a public health approach.⁶⁰ These laws can be divided into three broad categories based on whether they: (1) require research on the problem, (2) initiate preventative public education campaigns, or (3) provide drug treatment for pregnant addicts. One commonality is that none entail large public expenditures.

Although the specific mandates vary, thirteen states require additional research into the problems caused by substance abuse during pregnancy.⁶¹ Some states mandate the creation of a task force or commission to study the problem, while other states instruct an existing public agency to undertake a new study. Arkansas, California, Louisiana, Minnesota, North Carolina, and North Dakota limit the scope of such research programs to the needs of drug-exposed infants and children.⁶² Connecticut, Illinois, Nevada, New Hampshire, Oklahoma, and Oregon take a more holistic approach, requiring the study of both children and their mothers.⁶³ Washington requires the Department of Health to develop screening criteria to be used to identify pregnant addicts and then to use those in creating a training protocol to be used by medical providers.⁶⁴ No state limits the scope of research to the mothers only, which reflects the stigmatization and secondary status of drug abusing women even in states that emphasize the public health approach.

Sixteen states have passed laws designed to educate women about the harmful effects of using drugs when pregnant.⁶⁵ The content of the campaigns and their target audience varies from state to state. Some states require preventative education campaigns directed at the general public while other states have more specific target audiences. Among the former group, Arizona and Connecticut high schools must provide preventative drug education that covers the adverse effects of drug use by pregnant women.⁶⁶ Alaska distributes pamphlets with marriage licenses, which describe the harms caused by fetal alcohol syndrome and perinatal drug exposure,⁶⁷ and Delaware mandates that all professional counselors and medical practitioners must post and give written and verbal warning to pregnant patients about the possible problems, complications, and harms caused by narcotic use during pregnancy.⁶⁸

Among the states that target specific groups, most focus on pregnant women as a class. Colorado, Kansas, Louisiana, Massachusetts, and South Dakota have laws requiring that health care providers inform all pregnant

women of the adverse consequences of prenatal drug exposure. Minnesota simply requires that health care professionals be trained in effective drug prevention methods designed to reduce the number of drug exposed infants. Iowa law requires that birth center clients receive drug education,⁶⁹ and Maryland has a similar requirement for pregnant women receiving medical assistance.⁷⁰ North Dakota, Oregon, and Wisconsin target “high-risk” women patients in their education campaigns, although North Dakota’s program is limited to prevention of fetal alcohol syndrome.⁷¹

None of these initiatives directly meets the drug treatment needs of pregnant women already addicted to narcotics. Researchers unanimously agree that residential drug treatment programs that address the broader social context of women’s addiction are the most effective means of combating the problem of prenatal drug exposure.⁷² Most drug treatment programs were established in the 1950s and 1960s when heroin was the primary illegal drug and male addicts far outnumbered female ones.⁷³ The current situation is quite different. Women are at least as likely as men to be addicted to drugs. Roughly 60% of “crack” addicts are women.⁷⁴ Yet a National Institute on Drug Abuse study found that only one-quarter of addicts receiving treatment in 1990 were women, and only a minuscule proportion of these were pregnant.⁷⁵ The same survey found that only 0.1% of all addicts in treatment had access to childcare at their treatment centers.⁷⁶ Fears of insurance liability for drug-affected children are an important reason why many treatment providers refuse to accept pregnant women in their programs.

Despite the well-documented shortage of drug treatment programs willing to accept them,⁷⁷ the federal government has done very little to expand the number of available treatment slots for pregnant addicts. States receiving federal drug-treatment block grants were not required to allocate any funds for treatment of female addicts, much less pregnant addicts, until fiscal 1985, when block grant recipients had to spend 3% of their funds for alcohol and drug abusing women. That figure was later increased to 5%.⁷⁸

State governments have not chosen to pick up the slack left by the federal government. Neither state legislatures nor local governments have responded to the problem of prenatal drug exposure by increasing public funding for drug treatment targeted at pregnant addicts.⁷⁹ For example, in this legislative term, Connecticut failed to pass a bill that would have funneled proceeds of the sale of bonds to the Department of Correction to develop facilities and alternative sentencing programs for pregnant and parenting women.⁸⁰ The facilities would have housed pregnant or parenting women with a history of substance abuse who have one or more

children under the age of six at the time of entry into the program. It also would have allowed at least one child to reside with the mother in the facility.

Illinois is the only state that statutorily has earmarked part of a special fund for the provision of drug treatment services for pregnant addicts. Money from the Illinois Substance Abuse Services Fund is used to pay for the hospitalization of pregnant women with substance abuse problems.⁸¹ The Fund also pays for services to drug-affected newborns and supplements existing county funding for more generalized substance abuse treatment. Three other states, Florida,⁸² Pennsylvania,⁸³ and Rhode Island,⁸⁴ have passed laws that pledge the state to providing additional substance abuse treatment to pregnant women.

At least seven states passed laws authorizing the creation of pilot projects providing drug treatment to pregnant addicts.⁸⁵ Their limited scope and often uncertain funding render the chances of success doubtful. Two other states—Nebraska and Tennessee—have tried to improve access to existing services. Nebraska has implemented a case management program to ensure that high risk pregnant women, not covered by medical insurance, gain access to needed services, and Tennessee employs older women from the community to act as “resource mothers” for high-risk pregnant teenagers.⁸⁶ Neither of these programs expands the number of treatment slots available for pregnant addicts.

Instead of new programs, six states acted to prohibit drug treatment facilities from discriminating against pregnant women. Kansas, Louisiana, and Missouri have passed laws with specific anti-discrimination clauses,⁸⁷ and the latter two are also part of a group of five states that make treatment services for pregnant women a priority. Arizona, Georgia, and Maryland are the other states that prioritize the treatment of pregnant addicts.⁸⁸

Last November California voters overwhelmingly passed Proposition 36, which provides for a massive expansion in the number of drug treatment slots in the state.⁸⁹ Instead of incarceration, most drug addicts will be placed on probation and required to undergo treatment. The new law also mandates the creation of a Substance Abuse Treatment Trust Fund to provide for additional treatment slots. The Fund will receive a \$60 million appropriation from the General Fund in fiscal year 2000-01 and \$120 million for five subsequent fiscal years. Although the initiative does not make any special provisions for pregnant women or at-risk women, they would almost certainly benefit from the program.

CONCLUSION

As we have seen, two distinctly different policy approaches to substance abuse during pregnancy have been followed in the past fifteen years. Although punitive responses have been predominant within the criminal justice system, state legislative responses have been far more mixed. Only two state legislatures, those in Indiana and Utah, have solely adopted punitive means to combat drug abuse by pregnant women. An additional eighteen states have passed laws that approach the problem from both the punitive and public health perspectives. The remaining fifteen state legislatures have solely adopted public health measures. The failure of all levels of government to provide funding for these programs is a major impediment to their success. Perhaps the enactment of Proposition 36 will allay politicians' fears that voters equate drug treatment with the coddling of criminals.

Although prognosticating about future trends is always a risky proposition, it is particularly difficult at this time. As we have seen, both punitive and public health oriented measures have been adopted in the recent past. In its recent 6-3 decision in *Ferguson*, the U.S. Supreme Court held that involuntary drug testing of pregnant women violated the Fourth Amendment's prohibition on unreasonable searches and seizures.⁹⁰ The Court rejected the Fourth Circuit's argument that such tests were "minimally intrusive" and permissible under the "special needs" exception. While this decision will make it more difficult for prosecutors to pursue criminal actions against pregnant drug users, the Court carefully avoided addressing one of the central issues posed by these cases: whether the fetus can be legally defined as a "person." By doing so, the Court left open the possibility that prosecutors could continue to prosecute women for delivering drugs to their fetuses. The court only proscribed involuntary drug screening of the women, and not other means of gathering evidence of drug exposure. The most obvious way that such evidence could be obtained is by running drug screens on infants immediately following birth. Despite this caveat, the *Ferguson* decision, at the very least, should slow the rush toward increasingly punitive responses to drug use by pregnant women. It might even help shift the locus on policy initiatives away from the courts, which have been overwhelmingly punitive, and into the state legislatures.

Predicting what is likely to occur within the state legislatures, though, is equally difficult. Although most state laws have a public health orientation, there continues to be strong support for getting tough on pregnant drug users. The adoption of civil commitment statutes, especially

those that make it an offense for a pregnant woman to imbibe a legal substance—alcohol—is one indication of the continuing popularity of punitive measures. Finally, the question of whether the new Bush administration will opt for punitive or public health oriented initiatives remains.

References

1. Even though poverty contributes to a wide range of physical and developmental maladies, society refuses to provide adequate housing, nutrition, and medical care to pregnant women who are unable to procure these goods on their own. Moreover, there has been no comparable effort to criminalize individual male actions that threaten fetal well-being. The term "fetal abuse" has only been applied to harm caused by pregnant women's use of drugs or alcohol, but not to harm caused by physical assaults on pregnant women. *See, e.g.,* RACHEL ROTH, MAKING WOMEN PAY: THE HIDDEN COSTS OF FETAL RIGHTS (2000); Paul Peretz & Jean Reith Schroedel, *The Road not to Travel: A Comment on Deborah Mathieu's Proposal to Mandate Outpatient Treatment for Pregnant Substance Abusers*, 15 POL. & LIFE SCI. 67, 67-69 (1994).

2. 410 U.S. 113 (1973).

3. For a detailed history of the legal spillover from *Roe v. Wade* into other fetal policy areas, see Jean Reith Schroedel et al., *Women's Rights and Fetal Personhood in Criminal Law*, 7 DUKE J. GENDER L. & POL'Y 89 (2000).

4. Significantly, the greatest actual increase in cocaine use occurred in the 1970s when many middle-class whites experimented with the drug. The media, however, did not focus attention on drug use until the mid-1980s, when a cheap, inhaleable form of the drug—crack—became prevalent in the inner cities. Craig Reinerman & Harry G. Levine, *The Crack Attack: Politics and Media in the Crack Scare*, in CRACK IN AMERICA: DEMON DRUGS AND SOCIAL JUSTICE 18 (Craig Reinerman & Harry Levine eds., 1997) [hereinafter

CRACK IN AMERICA]. By the late 1990s crack use had declined dramatically, but drug use by pregnant women had not. A new drug, crack—a form methamphetamine—has become the drug of choice, but it has generated little media attention. Whether the lack of interest is due to public weariness about drug-exposed babies or to the fact that most of the crack-using pregnant women are white rather than minority women is debatable. JEAN REITH SCHROEDEL, IS THE FETUS A PERSON? A COMPARISON OF POLICIES ACROSS THE FIFTY STATES 102 (2000).

5. Much attention has been given to public opinion polls showing strong public support for making substance abusing pregnant women subject to criminal sanctions, but as Rachel Roth shows in her analysis of all the relevant polls, there is at least as much support for drug treatment as there is for incarceration. ROTH, *supra* note 1, at 157-58.

6. Somewhat ironically, the Supreme Court recognized nearly four decades ago that drug addiction is a medical problem rather than a criminal one. *Robinson v. California*, 370 U.S. 660 (1962).

7. Although police and district attorneys do not typically consult with policy experts prior to deciding whether to make an arrest or prosecute, there are opportunities for expert opinion to play a role in the courtroom. Judges have broad discretion over the type of expert testimony that can be presented. For research on judges and prosecutors' knowledge about the most effective responses to drug addiction among pregnant women, see Barrie Becker & Peggy Hora, *The Legal*

Community's Response to Drug Use During Pregnancy in the Criminal Sentencing and Dependency Contexts: A Survey of Judges, Prosecuting Attorneys, and Defense Attorneys in Ten California Counties, 2 S. CAL. REV. L. & WOMEN'S STUD. 527 (1993).

8. SCHROEDEL, *supra* note 4, at 118-20.

9. See, e.g., *Johnson v. State*, 602 So. 2d 1288, 1290 (Fla. 1992); *State v. Gray*, 584 N.E.2d 710, 710 (Ohio 1992); *Whitner v. State*, 492 S.E.2d 777, 778 (S.C. 1997); *People v. Hardy*, 469 N.W.2d 50, 51 (Mich. Ct. App. 1991); *Department of Social Services v. Nash*, 419 N.W.2d 1, 2 (Mich. Ct. App. 1987); *In re Theresa J.*, 158 A.D.2d 364 (N.Y. App. Div. 1990); *State v. Deborah J.Z.*, 596 N.W.2d 490, 491 (Wis. Ct. App. 1999).

10. Criminal prosecutions have taken place in the following states: Alabama, Alaska, Arizona, California, Connecticut, Florida, Georgia, Idaho, Illinois, Indiana, Kentucky, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Nebraska, Nevada, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin, and Wyoming.

11. For example, in 1992 the Ohio Supreme Court overturned a child abuse conviction for prenatal exposure to narcotics on the grounds that the term "child" refers only to a "born" child. *State v. Gray*, 584 N.E.2d 710 (Ohio 1992).

12. Molly McNulty, *Pregnancy Police: Implications of Criminalizing Fetal Abuse*, YOUTH LAW NEWS 33-37 (1990).

13. *State ex. rel. Angela M.W. v. Kruzicki*, 197 Wis. 2d 532; 541 N.W.2d 482

(Wis. Ct. App. 1995), *rev'd*, 209 Wis. 2d 112; 561 N.W.2d 729 (Wis. 1997).

14. *Whitner*, 492 S.E.2d 777.

15. *Whitner v. South Carolina*, 523 U.S. 1145 (1998).

16. *Ferguson v. City of Charleston*, 528 U.S. 1187 (2000).

17. *Id.*

18. Carmen Vaughn, *Circumventing the Fourth Amendment via the Special Needs Doctrine to Prosecute Pregnant Drug Users: Ferguson v. City of Charleston*, 51 S.C. L. REV. 857 (2000).

19. Center for Reproductive Law & Policy, *On the Docket: CRLP in the Courts*, at http://www.crlp.org/rfn_98_09.html (last visited Apr. 22, 2001). Even though the Supreme Court did not consider race discrimination issues in *Ferguson*, one *amicus curiae* brief argues that the criteria used to identify possible drug users were "thinly veiled proxies for low socioeconomic status or race." Brief of Amicus Curiae NARAL Foundation et al. at 23-26, *Ferguson v. City of Charleston*, 528 U.S. 1187 (2000) [hereinafter NARAL Brief]. The NARAL foundation also charges that the choice of a single hospital, one that serves a disproportionately poor and African-American population, was discriminatory, as was the decision to prosecute only women who tested positive for cocaine even though the screening test could detect other drugs. The brief also cites evidence showing that the individual responsible for choosing which patient's would be tested held racist beliefs and intervened to prevent at least one white woman from arrest after she tested positive. *Id.*

20. Janna Merrick, *Caring for the Fetus to Protect the Born Child? Ethical and Legal Dilemmas in Coerced Obstetrical Intervention*, 13 WOMEN & POL. 63, 63-81.

21. Vaughn, *supra* note 18, at 861.

22. Vivian Berger, *No Way to Treat a Baby*, NAT'L L.J., Nov. 13, 2000, at A21.

23. Vaughn, *supra* note 18, at 858.

24. LYNN M. PALTROW, CRIMINAL PROSECUTIONS AGAINST PREGNANT WOMEN (1992).

25. NARAL Brief, *supra* note 19.

26. SCHROEDEL, *supra* note 4; American Medical Association Board of Trustees Report, *Legal Interventions During Pregnancy: Court-Ordered Medical Treatment and Legal Penalties for Potentially Harmful Behavior by Pregnant Women*, 264 JAMA 2663, 2667 (1990).

27. Correctional institutions in the United States have not adopted the guidelines for minimum obstetrical and gynecological care promulgated by the American College of Obstetricians and Gynecologists, or any of the relevant medical associations. The American Medical Association, American Academy of Pediatrics, American Nurses Association, American Public Health Association, and American Society of Addiction Medicine, have all issued statements opposing the incarceration of pregnant addicts. Center for Reproductive Law and Policy, *Reproductive Freedom in Focus: Punishing Women for their Behavior, A Public Health Disaster*, 5-6 (on file with author). Furthermore, less than half of state prisons for women have policies governing the care of pregnant addicts. To make matters worse, drugs are widely available in prisons

and jails. See, e.g., Charles C. Egley et al., *Outcome of Pregnancy During Imprisonment*, 37 J. REPROD. MED. 131, 132 (1992); Janet S. Wilson & Renee Leasure, *Cruel and Unusual Punishment: The Health Care of Women in Prison*, 16 NURSE PRAC. 32, 35 (1991).

28. As of December 2000, the fifteen states without such laws are: Alabama, Alaska, Hawaii, Idaho, Maine, Michigan, Mississippi, Montana, New Mexico, New York, South Carolina, Texas, Vermont, West Virginia, and Wyoming. Some of these states had repealed earlier enactments and others had allowed the funding for earlier initiatives to expire. Also in some states, the relevant social service agencies have regulations and policies, written and unwritten, designed to address the problem.

29. LAURA E. GOMEZ, MISCONCEIVING MOTHERS: LEGISLATORS, PROSECUTORS, AND THE POLITICS OF PRENATAL DRUG EXPOSURE 41 (1997).

30. OR. REV. STAT. § 430.905 (1999).

31. OR. REV. STAT. § 430.910 (1999).

32. Although no state has passed statutes singling out pregnant women for additional sanctions for abusing narcotics, New Jersey passed a law doubling the criminal penalties against persons who distribute a controlled substance to a pregnant woman. N.J. STAT. ANN. § 2C:35-8 (West 1996).

33. Under Indiana House Bill 1184 (1994), a woman who gave birth to a drug affected child would have been guilty of a Class D Felony. Mississippi House Bill 670 (1994) also would have made it a felony for a woman to use a controlled substance during the last trimester of a pregnancy if it

resulted in the birth of an addicted child. The Indiana bill died, and committee killed the Mississippi bill.

34. *See, e.g., Kruzicki*, 561 N.W.2d 729 (holding that extending an involuntary civil commitment statute to cover pregnant substance abusing women would be usurping the role of the legislature).

35. *See, e.g., Judy Pasternak, Wisconsin OKs Civil Detention for Fetal Abuse*, L.A. TIMES., May 2, 1998, at A1, A13 (noting that at the Wisconsin legislature's debate over its civil commitment statute, representatives from the state's social service agencies testified that there was an acute shortage in drug treatment slots, and that the number of pregnant addicts voluntarily seeking treatment far exceeded the number of slots available in the state).

36. MINN. STAT. § 253B (1997).

37. S.D. CODIFIED LAWS § 34-20A-70 (Michie 1998); WIS. STAT. § 48.193 (1999).

38. WIS. STAT. § 48.193 (1999) (emphasis added).

39. The laws of the following states contain at least some punitive component: California, Illinois, Indiana, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, Nevada, Ohio, Oklahoma, Oregon, South Dakota, Tennessee, Utah, Virginia, Wisconsin. Social service agencies in some of the other states have adopted regulations that are punitively oriented. From the standpoint of the target population, the effect of these regulations may be substantially the same as statutes. However, trying to encompass all of the regulatory changes, as well as case and statutory laws would be a massive undertaking, so we will leave that to future

researchers.

40. MINN. STAT. § 626.556 (2000).

41. The seven states that require reporting of suspected cases of prenatal drug exposure to child welfare agencies or their equivalent are: California, Illinois, Kansas, Minnesota, Missouri, Utah, and Virginia. CAL. PENAL CODE § 11165.13 (2001); 325 ILL. COMP. STAT. 5/7.3b (2000); KAN. STAT. ANN. § 65-1,163 (1999); MINN. STAT. § 626.556 (2000); MO. REV. STAT. § 191.741 (1999); Utah Code Ann. § 62A-4a-404 (2000); VA. CODE ANN. § 32.1-127 (Michie 2000).

42. In Kentucky a positive newborn toxicology test must be evaluated to determine whether abuse or neglect has occurred and whether an investigation is necessary. KY. REV. STAT. ANN. § 214.160 (Banks-Baldwin 2001). The remaining six states, Indiana, Iowa, Nevada, Oklahoma, Oregon, and Wisconsin, do not specifically require suspected prenatal drug exposure to be reported. However, they do categorize such infants as "need[y]," subject[s] of protective services," or "abused," thereby triggering normal reporting requirements.

43. JESSICA PEARSON & NANCY THOENNES, THE IMPACT OF LEGISLATION AND COURT DECISIONS DEALING WITH DRUG-AFFECTED BABIES 58-60 (1995).

44. *Id.*

45. MINN. STAT. ANN. § 626.556 (2000). According to Pearson and Thoennes, the prenatal drug laws in Minnesota are "perhaps the strongest in the nation," but the punitive intent of the laws is undercut by the state's traditional approach to treating substance abuse as a public health

problem rather than a criminal matter. PEARSON & THOENNES, *supra* note 43, at 49-50.

46. MO. ANN. STAT. § 191.737 (2000).

47. NEV. REV. STAT. 432B.330 (1999).

48. OKLA. STAT. tit. 10, § 7001-1.3 (2000).

49. IND. CODE § 31-34-1-10 (1997).

50. IOWA CODE § 232.68 (1997).

51. For example, in 1999 a Virginia Senate bill proposed expanding the definition of "abused or neglected child" to include "newborn infants testing positive for a controlled substance not prescribed by a physician, born dependent on such drug, or diagnosed by a physician with a condition which is attributable to *in utero* exposure to illegal drugs or fetal alcohol syndrome." S. 576 (Va. 1998). The legislative session ended before the bill was considered on the floor.

52. OR. REV. STAT. § 430.915 (1999).

53. WIS. STAT. § 48.02 (2000).

54. Loren Siegal, *The Pregnancy Police Fight the War on Drugs*, in CRACK IN AMERICA, *supra* note 4.

55. VA. CODE ANN. § 63.1-248.3 (Michie 2000).

56. *Id.*

57. CAL. PENAL CODE § 11165.13 (West 2001).

58. PEARSON & THOENNES, *supra* note 43, at 67-68.

59. Drug addiction is classified as a disease by the American Psychiatric Association. AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF DISORDERS (1994). The International Classification of Diseases also includes drug dependence as a medical

condition. INTERNATIONAL CLASSIFICATION OF DISEASES, 1 ICD-9-CM 49-50 (5th ed., 9th rev., 1997).

60. The thirty-three states with at least some public health oriented laws are: Arizona, Arkansas, California, Colorado, Connecticut, Delaware, Georgia, Florida, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Tennessee, Virginia, Washington, and Wisconsin.

61. The thirteen states that require studies are: Arkansas, California, Connecticut, Illinois, Louisiana, Minnesota, Nevada, New Hampshire, North Carolina, North Dakota, Oklahoma, Oregon, and Washington. North Dakota limits the research to the problem of fetal alcohol syndrome.

62. *E.g.*, LA. REV. STAT. ANN. § 46:2514 (West 2000); N.D. CENT. CODE § 15-11-35 (2000).

63. *E.g.*, 55 ILL. COMP. STAT. 5/5-1086.1 (2000); N.H. REV. STAT. ANN. § 442.395 (2001).

64. WASH. REV. CODE § 70.83C.020 (2000).

65. The sixteen states with preventative public education initiatives designed to warn women of the dangers of using drugs while pregnant are: Arizona, Colorado, Connecticut, Delaware, Iowa, Louisiana, Kansas, Maryland, Massachusetts, Minnesota, New Jersey, North Carolina, North Dakota, Oregon, South Dakota, and Wisconsin. Again, the focus in North

Dakota is on the prevention of fetal alcohol syndrome. New Jersey also limits its education campaign to warning against the use of alcohol during pregnancy.

66. ARIZ. REV. STAT. § 15-712 (2000); CONN. GEN. STAT. §17a-701 (1999).

67. ALASKA STAT. § 25.05.111 (Michie 2000).

68. DEL. CODE ANN. tit. 16, § 190 (2000).

69. MINN. STAT. § 145.9265 (2000).

70. MD. CODE ANN., [HEATH-GEN. I] § 8-403.1 (2001).

71. N.D. CENT. CODE § 15-11-35 (2000); OR. REV. STAT. § 430.905 (1999); WIS. STAT. § 48.245 (2000).

72. See, e.g., CAROL TRACY ET AL., WOMEN, BABIES, AND DRUGS: FAMILY-CENTERED TREATMENT OPTIONS 13 (1990); LaRay Brown, *Women and Children Last: Barriers to Drug Treatment for Women*, 22 HEALTH/PAC BULL. 15, 18 (1992); George DeLeon & Nancy Jainchill, *Residual Therapeutic Communities for Female Substance Abusers*, 67 J. N.Y. ACAD. MED. 277, 279 (1991); Kathleen J. Farkas & Theodore V. Parran, Jr., *Treatment of Cocaine Addiction During Pregnancy*, 20 CLINICS PERINATOLOGY 29, 39 (1993).

73. For an excellent history of substance abuse among women in the United States and governmental responses to the problem, see STEPHEN R. KANDALL, *SUBSTANCE AND SHADOW: WOMEN AND ADDICTION IN THE UNITED STATES* (1996).

74. Gillian Walker et al., *A Descriptive Outline of a Program for Cocaine-Using Mothers and Their Babies*, 3 J. FEMINIST FAM. THERAPY 7 (1991).

75. NATIONAL INSTITUTE OF DRUG

ADDICTION, *DRUG SERVICES RESEARCH SURVEY: FINAL REPORT, PHASES I AND II*, at 35 (Biggl Inst. for Health Policy at Brandeis University, 1992).

76. *Id.* at 45.

77. See, e.g., LAURA FEIG, OFFICE OF HUMAN SERV. POL'Y, U.S. DEP'T OF HEALTH AND HUMAN SERV., *DRUG EXPOSED INFANTS AND CHILDREN: SERVICE NEEDS AND POLICY QUESTIONS* 16 (1990); Wendy Chavkin, *Mandatory Treatment of Pregnant Substance Abusers: Irrelevant and Dangerous*, 15 POL. & LIFE SCI. 50, 53 (1996); Kary L. Moss, *Substance Abuse During Pregnancy*, 13 HARV. WOMEN'S L.J. 278, 288 (1990); Lynn M. Paltrow, *Perspective of a Reproductive Rights Attorney*, 1 FUTURE CHILD. 85, 85 (1991); Tiffany M. Romney, *Prosecuting Mothers of Drug-Exposed Babies: The State's Interest in Protecting the Rights of a Fetus Versus the Mother's Constitutional Rights to Due Process, Privacy and Equal Protection*, 17 J. CONTEMP. L. 325, 341 (1991).

78. Health Services Amendments of 1985, Pub. L. No. 99-117 (Oct. 7, 1985).

79. Chavkin, *supra* note 77, at 50.

80. S. 604 (Conn. 2000).

81. 55 ILL. COMP. STAT. 5/5-1086.1 (2000).

82. In 1996 the Florida state legislature created the Pregnancy Outcomes Program, committing each county health program to provide services to indigent pregnant women at risk of medical complications due to drug or alcohol abuse. FLA. STAT. 154.011 (1996).

83. In 1997 Pennsylvania enacted a law mandating that the state Department of Health has a "duty" to provide residential drug and alcohol treatment and related

services to pregnant women with substance abuse problems. PA. ADMIN. CODE § 2123 (1997).

84. In 1996 the Rhode Island state legislature instructed the Department of Human Services to “provide enhanced services” to a wide range of pregnant women eligible for state funded medical assistance. Although outpatient drug treatment was among the enumerated services, the exact level of commitment is yet to be determined. R.I. GEN. LAWS § 42-12.3-3 (1996).

85. The seven states that passed laws enabling pilot projects to be developed are California, Colorado, Kentucky, Minnesota, Ohio, Virginia and Washington. The Ohio and Virginia laws specifically require that these programs will use only available funds. Washington state also has been the site of two federally funded demonstration projects that provide drug treatment and other services to pregnant women and mothers with substance abuse problems. For a description of the federal projects, see PEARSON & THOENNES, *supra* note 43.

86. NEB. REV. STAT. § 68-1058 (2001); TENN. CODE ANN. § 68-24-104 (2001).

87. KAN. STAT. ANN. § 65-1,165 (2000); LA. REV. STAT. ANN. § 46:2505 (West 2000); MO. REV. STAT. § 191.731 (1999).

88. The failure to expand treatment slots is even more paradoxical when one considers recent research that shows that drug treatment is a far more cost-effective means of combating narcotics addiction than is incarceration. C. PETER RYDELL & SUSAN S. ERVINGHAM, CONTROLLING COCAINE: SUPPLY VERSUS DEMAND PROGRAMS (RAND Corporation ed., 1996). This was

corroborated in a study performed by the California Department of Alcohol and Drug Programs, which found that for every dollar spent on drug treatment taxpayers saved seven dollars that would otherwise be spent on crime and health care. NAT’L OPINION RESEARCH CTR., CAL. DEP’T OF ALCOHOL & DRUG PROGRAMS, EVALUATING RECOVERY SERVICES: THE CALIFORNIA ALCOHOL AND DRUG TREATMENT ASSESSMENT 1 (1994).

89. Substance Abuse & Crime Prevention Act of 2000 (Proposition 36) (to take effect July 1, 2001), *available at* <http://www.adp.cahwnet.gov/SACPA/pro36.shtml> (last visited Apr. 22, 2001).

90. *Ferguson v. City of Charleston*, 121 S. Ct. 1281 (2001).

